MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01503

Reg. Diat. No. 761

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster Md - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: 414 E Main St Westminster Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: (Rural) (If rural, give LOCATION)

2.(a) If veteran, name war: East Main St Extd

3. (a) FULL NAME: William H. S. Allgire

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of ~~husband~~ or wife: Mary R Allgire

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 28 - 1853

8. AGE:

Years	Months	Days	If less than one day
93	7	14	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business

FATHER — 12. Name: Melchior H Allgire

FATHER — 13. Birthplace: md

MOTHER — 14. Maiden name: Julia Ann Hovak

MOTHER — 15. Birthplace: Md

16. Informant: A. Claude Allgire

Address: Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 14/47 (month) (day) (year)

Cemetery or crematory: Medley

Location: Carroll Co. Md

18. Funeral director: Edw. Shipton

Address: Hampstead Md

19. 2/12 (Date rec'd by registrar) 19 47 Ray Fogle Dep Reg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 - 12 - 1947 at 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to Feby 12 1947 and that I last saw him alive on Feby 12 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	6 hrs
Due to: myocarditis	3 mos
Due to: Arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm R Fouty MD M. D. or other

Address: Westminster Md Date signed 2-12-47

1-25

2-760 —— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

01504

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 month, 29 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Farm Labor Camp
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: CHRISTOPHER BALL

3.(b) Social Security Number: lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Essie Ball

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 6, 1901

8. AGE:

Years	Months	Days	If less than one day
45	10	28	..... hrs. ..... min.

9. Birthplace: Mt. Pleasant, S. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Hammond Ball
13. Birthplace: Unknown

MOTHER
14. Maiden name: Laura Grant
15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal: Which?) Date thereof: 2-7-47 (month) (day) (year)

Cemetery or crematory: St. Luke's Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Warner

Address: Sykesville, Md.

19. 2-4 (Date rec'd by registrar) 19 47 Albert Richardson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4, 1947 at 6.20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1946 to Feb. 4, 1947 and that I last saw him alive on February 4, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 2-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1-25

2-740 - 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61505 P.

Reg. Diat. No. 7K

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 2 mons. 27 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 9 yrs. 2 mons. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give resideoee of mother)

State: Maryland County: Balto.

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 502 Stanley Road

(If rural, give LOCATION)

2.(a) If veteran, name war: Stoneleigh

3.(a) FULL NAME: John Bancroft

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 8, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	5	19		

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Electrotyper

11. Industry or business:

FATHER — 12. Name: John Bancroft

FATHER — 13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Mary Willey

MOTHER — 15. Birthplace: Harford County, Maryland

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 1 1947 (month) (day) (year)

Cemetery or crematory: Greenmount Cem

Location: Oliver & Greenmount Ave

18. Funeral director: John C Moran

Address: 3000 E Baltimore St

19. 2/28 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27, 1947, at 1:10a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1946, to Feb. 27, 1947 and that I last saw him alive on February 26, 1947

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	10 yrs.
Due to:	
Due to:	
Other conditions: Psychosis with cardio-vascular disease	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Howard N Frederickson M.D. M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed 2/27/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01506

Reg. Dist. No. 710

1. PLACE OF DEATH:
County Carroll
City or town Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Uniontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Augustus Peter Bankart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife Annie Bankart
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 20 1859

8. AGE: Years	Months	Days	If less than one day
87	4	5	..... hrs. ..... min.

9. Birthplace Carroll Co. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Wm Bankert
13. Birthplace Carroll Co.
MOTHER 14. Maiden name Mary Snyder
15. Birthplace Carroll Co.
16. Informant Maurice Bankart
Address Uniontown Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 28-47 (month) (day) (year)
Cemetery or crematory Kriders
Location Carroll Co.
18. Funeral director W. Bankard Son
Address Westminster, Md.
19. Feb 27 1947 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1947 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1947, to Feb 24 1947
and that I last saw h[illegible] alive on Feb 23 1947
Immediate cause of death Organic Heart Disease — DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Johnson Stewart M. D. or other
Address Westminster Md Date signed Feb 27 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 01507

Reg. Dist. No. 7-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County. Carroll

City or town. Uniontown Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Uniontown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carrie Ellen Bankard

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife J. J. Bankard

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jun. 11 - 1880

8. AGE: Years	Months	Days	If less than one day
67	1	5	....hrs. ....min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Mustaman

13. Birthplace Md.

MOTHER 14. Maiden name Amelia Myers

15. Birthplace Md.

16. Informant Mrs. Floyd Devilbiss

Address Uniontown R.D. # 1. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 19 1947 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Uniontown, Md.

18. Funeral director H. Bair Rand & Son

Address Westminster, Md.

19 Feb. 19 1947 (Date rec'd by registrar) Margaret P. Engler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1947, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1946, to Feb 17 1947 and that I last saw h... alive on Feb 12 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D. or other

Address Union Bridge Date signed 2-17-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01508

Reg. Dist. No. 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
County Carroll
City or town Bond St. Ext. Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll Co.
City or town Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bond St Ext
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Columbus Baust

3.(b) Social Security Number 213-18-1232

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1865

8. AGE: Years	Months	Days	If less than one day
81	5	1	..... hrs. ..... min.

9. Birthplace Carroll Co. (Town, county, and state)
10. Usual occupation Janitor
11. Industry or business

FATHER
12. Name Samuel Baust
13. Birthplace Md.

MOTHER
14. Maiden name Mary Jane Bankard
15. Birthplace

16. Informant Maurice Baust
Address Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Wed 26th 47 (month) (day) (year)
Cemetery or crematory Baust Cemetery
Location Nr. Westminster
18. Funeral director A. Bankard & Son
Address Westminster Md.
19. 2/26 47 (Date rec'd by registrar) (19) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 19 47 at 10:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22-47 19 ..... to Feb 23 19 47
and that I last saw h.. alive on Feb 22 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James T Moore M. D. or other
Address Westminster Md. Date signed 2/26/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 015960

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 285 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Arthur V. Blizzard

3.(b) Social Security Number: 217-12-5164

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Florence K. Blizzard

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 8, 1892

8. AGE: Years	Months	Days	If less than one day
54	5	4	..... hrs. ..... min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business

FATHER

12. Name: Harry C. Blizzard

13. Birthplace: Maryland

MOTHER

14. Maiden name: Emma E. Fowler

15. Birthplace: Maryland

16. Informant: Florence K. Blizzard

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/15/47 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 2/13 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 19 47, at 8 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10. 46 19 to Feby. 12. 19 47

and that I last saw him alive on Feby. 12. 19 47

	DURATION
Immediate cause of death: Carcinoma Lung spleen & Intestines	3 mos.
Due to: Primary in Hepatic flexure of colon. Cancer.	
Due to:	
Other conditions: Abdominal carcinomatosis.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas R. Fout MD M. D. or other

Address: Westminster Md. Date signed 2.13.47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

Reg. Dist. No. 1519 960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Eastview (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Eastview (If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural - Westminster (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Florence M. Blizzard.

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John L. Blizzard deceased
8.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): March 6 1861

8. AGE: Years: 85 Months: 11 Days: 8 If less than one day: ____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Charles Williams
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth Naylor
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. Ernest Flowers
Address: Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-12-47 (month) (day) (year)
Cemetery or crematory: Deer Park
Location: Smallwood, Carroll Co. Md.
18. Funeral director: C. M. Walter
Address: Winfield Md.
19. 2/12 47 (Date rec'd by registrar) 19____ C. Kriedman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 9th 1947 at 10.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to Feby 9 1947 and that I last saw h[illegible] alive on Feby 6 1947

	DURATION
Immediate cause of death: acute Cardiac dilatation	6 hrs
Due to: Chronic Myocarditis	2 yrs
Due to: Arterio-sclerosis	6 yrs.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: Edward R. Foutz MD M. D. or other
Address: Westminster Md. Date signed 2-10-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Diat. No. 8151 0

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Horace A. Bostian

3.(b) Social Security Number: 213-03-1014A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Lottie M. Bostian
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 8, 1874

8. AGE: Years: 72 | Months: 5 | Days: 29 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Retired Machinist

11. Industry or business:

FATHER — 12. Name: Jacob Bostian
13. Birthplace: Md

MOTHER — 14. Maiden name: Sarah Eyler
15. Birthplace: Md

16. Informant: Mrs Horace A. Bostian
Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/9/1947 (month) (day) (year)
Cemetery or crematory: Haugh's
Location: Near Keymar, Md

18. Funeral director: C. O. Fuss & Son
Address: Taneytown, Md.

19. Feb 8, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6 1947, at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1947, to Feb 6 1947
and that I last saw h... alive on Feb 5 1947

Immediate cause of death	DURATION
a) Uremia Sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Legg, M. D. or other
Address: Union Bridge Date signed 2-8-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01512

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 15 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1705 Brentwood Avenue (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PURNELL BOULDEN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1900

8. AGE:

Years	Months	Days	If less than one day
46	8	5	hrs. min.

9. Birthplace: Gracenville, Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Solomon Boulden
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susan Morris
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-10-47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Cedar Hill Md.
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave.

19. 2-7 19 47 (Date rec'd by registrar) Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7, 19 47, at 5.10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 19 46, to Feb., 7, 19 47 and that I last saw him alive on February 7, 19 47

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb. 10 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Foman, M. D. M. D. or other
Address: Henryton, Md. Date signed 2-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01513

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 1 day

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 33 Larkin Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FRANK WILLIAM BOYD

3.(b) Social Security Number: 220-22-3559

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Boyd

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): March 29, 1923

8. AGE: Years	Months	Days	If less than one day
23	10	17	....hrs. ....min.

9. Birthplace: Las Vegas, Nevada (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: David Boyd

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Mary Zelmar

MOTHER 15. Birthplace: Unknown

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 19-47 (month) (day) (year)

Cemetery or crematory: Brewer Hill Cemetery

Location: Annapolis, Md

18. Funeral director: J. B. Johnson

Address: Annapolis, Md.

19. Feb. 16, 1947 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16, 1947 at 7.35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1946 to Feb. 16, 1947 and that I last saw him alive on February 16, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) ....(County) ....(State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: ....Injured at work?

23. SIGNATURE: Reuben W. Offman, M. D. M. D. or other

Address: Henryton, Md Date signed: 2-16-47

1-25

2-740 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (730)

CERTIFICATE OF DEATH

Reg. Dist. No. 01514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Near Marriottsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural, Marriottsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Margaret Ann Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles H. Brown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30th 1869

8. AGE: Years	Months	Days	If less than one day
77	6	27	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home

FATHER
12. Name: George Fisher
13. Birthplace: Germany

MOTHER
14. Maiden name: Ellen Binnix
15. Birthplace: Unknown

16. Informant: Charles H. Brown
Address: Marriottsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 1 1947 (month) (day) (year)
Cemetery or crematory: Springfield
Location: Sykesville, Md.

18. Funeral director: C. H. Weer
Address: Sykesville Md.

19. Feb 27 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26th 1947 19 ..., at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19 ..., to 2/26 19 47
and that I last saw her alive on 2/26/47 19 ...

Immediate cause of death	DURATION
Chronic myocarditis	
Chronic arteriosclerosis	
Due to senile changes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. H. Lawson, M.D. M. D. or other
Address: Sykesville Date signed 2/26/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-e)

CERTIFICATE OF DEATH

★ 01515 8

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years, 4 months, 3 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 11 years, 4 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: City
City or town: 2162 Woodberry Avenue
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Baltimore, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Charles Edward Chalk

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/9/1889

8. AGE: Years	Months	Days	If less than one day
57	11	18	hrs. min.

9. Birthplace: Laurel, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Mill
FATHER 12. Name: Charles Chalk
13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth Stanton
15. Birthplace: Maryland
16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 2/47 (month) (day) (year)
Cemetery or ~~crematory~~: Ivy Hill
Location: Laurel, Md.
18. Funeral director: Thurnwald & Donovan
Address: 3615-17 Chestnut Ave
19. 3/1 (Date rec'd by registrar) 19 47 A. M. Hedrick per L.E. Registrar

1525

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27, 19 47, at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 19 41, to Feb 27 19 47
and that I last saw h im alive on 2/27 19 47

	DURATION
Immediate cause of death: Bronchogenic Carcinoma	4 months
Due to:	
Due to:	
Other conditions: Schizophrenia (include pregnancy within 3 months of death)	22 yrs.

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eckert, M.D. M. D. or other
Address: Sykesville, Maryland Date signed: 2/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

01516

Reg. Dist. No. 830

1. PLACE OF DEATH:
County: Carroll
City or town: Woodtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Minnie M. Chaney

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Geo. M. Chaney deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec. 31, 1866
8. AGE: Years: 80 Months: 1 Days: 27 If less than one day: hrs. min.
9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: John Harrison
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Bosnell
15. Birthplace: Maryland
16. Informant: Mrs. Harry Brown, Sr.
Address: Woodtown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-3-1947 (month) (day) (year)
Cemetery or crematory: Morgan Chapel
Location: Day, Carroll Co., Md.
18. Funeral director: C. M. Waltz
Address: Winfield, Md.
19. Mar 2 1947 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1947 at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1946 to Feb 28 1947 and that I last saw h.e.r. alive on Feb 27 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	
and General Metastasis —	
Complicated with	
Chronic Nephritis	
Due to Skull Injury accidental	
Fall —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. Waltz M. D. or other
Address: Mt Airy Md Date signed 3/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9a)

CERTIFICATE OF DEATH

01517

Reg. Dist. No. 740

1. PLACE OF DEATH:

County: Carroll

City or town: Johnsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Johnsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural --Sykesville

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MILTON L. COOK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1937

8. AGE:

Years	Months	Days	If less than one day
10	10	29	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: In School

11. Industry or business

FATHER 12. Name: Luther Edward Cook

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Eugenia Chase

MOTHER 15. Birthplace: Maryland

16. Informant: Luther E. Cook

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-24-47 (month) (day) (year)

Cemetery or crematory: Johnsville

Location: Johnsville, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. Feb 22 1947 (Date rec'd by registrar) Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21, 1947 at 7:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19 to Feb 21 1947 and that I last saw h.. alive on Feb 21, 1947

Immediate cause of death	DURATION
acute bacterial endocarditis	5 days
Due to acute exacerbation Rheumatic fever	4yrs -
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm Lamont M.D. M. D. or other

Address: Sykesville, Md Date signed 2/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-D)

CERTIFICATE OF DEATH

01518

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 11 mon. 14 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 yr. 11 mon. 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: Joseph Cosgrove

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1894

8. AGE: Years: 53 Months: Days: If less than one day: hrs. min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-6-47 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cemetery
Location: Sykesville, Md.

18. Funeral director: C. Harry Warr
Address: Sykesville, Md.

19. Feb 6 1947 (Date rec'd by registrar) C. Harry Warr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4, 1947, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1945, to Feb. 4, 1947 and that I last saw him alive on February 4, 1947

Immediate cause of death	DURATION
Cellulitis of leg	3 mo.
Due to: Chronic myocarditis and myocardial degeneration	
Due to:	
Other conditions: Schizophrenia, hebephrenic type	30 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. of other
Springfield State Hospital
Address: Sykesville, Maryland
Date signed: 2-4-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

★ Reg. Diat. No. MV 01510 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Mt Airy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Fourteen

Hospital, Institution, or street address where death occurred:
Mt Saint Joseph

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Frederick PC.

City or town: Washington 30
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5809 Carlton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: N

3.(a) FULL NAME: Mary Jane Carlton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: Harold Wadsworth Carlton

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 23 1893

8. AGE:

Years	Months	Days	If less than one day
53	7	23	....hrs. ....min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Michael McCaffery
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Henrietta Trump
15. Birthplace: Fred. Co. Md.

16. Informant: Miss Alma McCaffery
Address: Liberty St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 7 - 1947 (month) (day) (year)

Cemetery or crematory: St. Johns Cem.

Location: Westminster, Md.

18. Funeral director: A Bankard Sons

Address: Westminster, Md.

19. 2/7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1947, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Fractured Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Feb. 4-47

Where did injury occur? Mt Airy Carroll Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Route 27

Means of injury: Automobile Accident Injured at work?

23. SIGNATURE: James T. Monroe, Deputy Medical Examiner
M. D. or other

Address: Westminster Md Date signed: 2-4-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-C)

★ 01520

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Feesersburg
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Grant Crouse

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary Catherine Crouse

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1, 1864

8. AGE:

Years	Months	Days	If less than one day
82	9	1	..... hrs. ..... min.

9. Birthplace Carroll County Maryland
(Town, county, and state)

10. Usual occupation Marble Cutter

11. Industry or business Marble Industry

FATHER 12. Name William Crouse

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Not Known

MOTHER 15. Birthplace Not Known

16. Informant Mrs Addie Crumbacker

Address Union Bridge Md R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5 1947 (month) (day) (year)

Cemetery or crematory Mt Union Lutheran Cemetery

Location Mt Union

18. Funeral director D D Hartle & Sons

Address Union Bridge & New Windsor Md

19. Feb. 4 1947 (Date rec'd by registrar) Eichman Registrar
Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1947, at 10:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to Feb 2 1947 and that I last saw h... alive on Feb 1 1947

Immediate cause of death	DURATION
Paralysis of Heart	
Due to Stomach Ulcer	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J A Martin M.D.
M. D. or other

Address Johnsville Md Date signed Feb 3

2-25

2-810 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01521

CERTIFICATE OF DEATH

Reg. Diat. No. 750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Manchester #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Laura Brock Crumrine

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	M.

6.(b) Name of husband or wife Aaron Crumrine
6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1864

8. AGE: Years 82 Months 5 Days 11 If less than one day ..... hrs. ..... min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Edward Sterner
13. Birthplace Carroll Co. Md
MOTHER
14. Maiden name Rebecca Shaw
15. Birthplace Carroll Co Md

16. Informant Mrs. Mabel Seiverson
Address 30 Monroe St. Hanover Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17 1947 (month) (day) (year)
Cemetery or crematory St. Mary's Cemetery
Location Hanover Pa. R.D.
18. Funeral director M. A. Heiser
Address Hanover Pa. ~~Feb. 14/47~~

19. Feb. 14 1947 Mrs. W. P. S Bower
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1947, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5 1947 to February 14 1947 and that I last saw h... alive on February 13 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 days
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph E Buck M.D.
M. D. or other
Address Taneytown Md. Date signed 2-17-47

1-35

Evidence for the change of age is shown on G109 3/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01522

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 3 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No.: 302 North Locust Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Bentz Davis

3.(b) Social Security Number: 217-10-3406

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nancy Kline
A.H.F. 6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): 3/2/91

8. AGE: Years	Months	Days	If less than one day
55	11	24 20 A.H.F.	hrs. min.

9. Birthplace: Franklin, Pennsylvania (Town, county, and state)
10. Usual occupation: Guard clerk
11. Industry or business:
FATHER 12. Name: Ira Davis
13. Birthplace: Allegany County, Maryland
MOTHER 14. Maiden name: Elizabeth Shaffer
15. Birthplace: Allegany County, Md.
16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 1 1947 (month) (day) (year)
Cemetery or crematory: Westminster Cem.
Location: Carlisle, Pa.
18. Funeral director: Fred W. Krauss
Address: Hagerstown, Md.
19. Feb. 26 1947 (Date rec'd by registrar) C. Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/26 19 47 at 2:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/23 19 47 to 2/26 19 47 and that I last saw him alive on 2/26/47 19

Immediate cause of death	DURATION
General Paresis of the Insane	unknown
Due to: Contributory Cause - Malaria (artificially induced)	1 week
Due to:	
Other conditions: Psychosis, syphilitic meningo-encephalitis	1½ yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other
Address: Sykesville, Maryland Date signed: 2/26/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01523

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 John St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Wilson Ebaugh

3.(b) Social Security Number 7004

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Celia Starner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 17 1873

8. AGE: Years	Months	Days	If less than one day
73	8	19	..... hrs. ..... min.

9. Birthplace Hauckville Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Joel Ebaugh
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Sarah Routson
15. Birthplace Carroll Co. Md.
16. Informant Vernon E Baugh
Address 119 E. Green St. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 8-1947 (month) (day) (year)
Cemetery or crematory Wesley cemetery
Location Hauckaville, Md.
18. Funeral director H Buckland & Son
Address Westminster, Md.
19. 2/7 19 47 H Buckland (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 19 47, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31st 19 47, to February 6th 19 47 and that I last saw him alive on February 6 19 47

Immediate cause of death	DURATION
Lobar Pneumonia	7 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. Luther Bair (M.D.) M.D. or other
Address Westminster, Md. Date signed 2/6/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

★ 01524

Reg. Dist. No. 74 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 mo., 18 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr., 2 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Celler Allen Eieener (alias Eineener)

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	unknown

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: unknown Months: Days: If less than one day: hrs. min.

appears about age 65 yrs.

9. Birthplace: Michigan (?) (Town, county, and state)

10. Usual occupation: vagrant

11. Industry or business:

FATHER 12. Name: unknown

13. Birthplace:

MOTHER 14. Maiden name: unknown

15. Birthplace:

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 19, 1947 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Feb 19 1947 C. Harry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 1947 at 1:47 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1946 to Feb. 16, 1947 and that I last saw him alive on February 16 1947

Immediate cause of death	DURATION
Arteriosclerosis, more than	2 yrs.
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis, more than	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: See cause of death above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D. M. D. of other

Springfield State Hospital

Address: Sykesville, Maryland Date signed: 2-16-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

01525

CERTIFICATE OF DEATH

Reg. Dist. No. 811

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Md. County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Helen J. Englebrecht

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Lewis Englebrecht

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1861

8. AGE:

Years	Months	Days	If less than one day
86	0	15	hr. ..... min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name John Stauffer

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Mary Catherine Wolfe

15. Birthplace Carroll Co. Md.

16. Informant Mrs. Roland Harmon

Address Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8, 1947 (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown Md

18. Funeral director Ed Bussard Son

Address Taneytown Md

19. Feb. 6 1947 (Date rec'd by registrar) Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1947, at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1946, to Feb 6 1947

and that I last saw h... alive on Feb 6 1947

Immediate cause of death	DURATION
Cirrhosis Sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Hugg M. D. or other

Address Union Bridge Date signed 2-6-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-810 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01526

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1337 Clinner Heights Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Alice Erementrout

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 1876

8. AGE: Years: 70 Months: 5 (?) Days: unk. If less than one day: hrs. min.

9. Birthplace: Fairfax, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Ira Deavers

FATHER — 13. Birthplace: Fairfax, Virginia

MOTHER — 14. Maiden name: Elizabeth Hanover

MOTHER — 15. Birthplace: Fairfax, Virginia

16. Informant: Springfield State Hospital records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17, 1947 (month) (day) (year)

Cemetery or crematory: Woodlawn.

Location: Woodlawn Md.

18. Funeral director: C. Hemmick & Donovan.

Address: 305-17 Chestnut Ave.

19. Feb. 15 1947 (Date rec'd by registrar) C. Henry Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15, 1947 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1947 to February 15 1947 and that I last saw h[illegible] alive on [illegible] February 15 1947

Immediate cause of death	DURATION
Chronic Myocarditis	unkn.
Due to: Generalized Arteriosclerosis	unkn.
Due to:	
Other conditions: Psychosis & Cerebral Arteriosclerosis	unkn.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.

M. D. or other

Address: Springfield State Hospital, Sykesville, Md. Date signed 2-15-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01527

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 4 mos 13 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 4 mos 13 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Lutherville (If outside city or town limits, write RURAL and give nearest town)

Street No.: York Road (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ethel May Flowers

3.(b) Social Security Number:

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Harry Flowers

6.(c) If wife, give age: ... years

7. Birth date of deceased (mo., day, yr.): Jan 28 - 1886

8. AGE: Years: 61 Months: Days: 13 If less than one day: ... hrs. ... min.

9. Birthplace: Maryland (Town, County, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER

12. Name: Samuel Burton

13. Birthplace: Md.

MOTHER

14. Maiden name: Sara Cockey

15. Birthplace: Md.

16. Informant: Mrs. Sara Easterhaupt

Address: Lutherville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 13 1947 (month) (day) (year)

Cemetery or crematory: Woodland Memorial Park

Location: Parkville, Md.

18. Funeral director: John Burns' Sons

Address: Towson Md.

19. 2/12 1947 (Date filed by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10th 1947 at 1150 P.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Sept 28th 1944 to Feb 10 1947 and that I last saw her alive on Feb 10 1947

Immediate cause of death: Lobar Pneumonia — DURATION: 4 da

Due to: Chr. Myocarditis — 4 yrs

Due to: Seni Arterio Sclerosis — ?

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W. F. Gastin M.D. (M. D. or other)

Address: Sykesville Date signed: 2/10/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the addition of usual residence of deceased is shown on G 109 4 2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

CERTIFICATE OF DEATH

A 01528

Reg. Diat. No. 8/1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alva Curtis Garner

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 15, 1865

8. AGE:

Years	Months	Days	If less than one day
81	3	12	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Retired merchant
11. Industry or business:
12. FATHER Name: Ephrim Garner
13. Birthplace: Md
14. MOTHER Maiden name: Jerusha Priest
15. Birthplace: Md
16. Informant: J. Fielder Gilbert
Address: Uniontown, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2, 1947 (month) (day) (year)
Cemetery or crematory: Church of God
Location: Uniontown Md
18. Funeral director: Lee Bussard Son
Address: Taneytown Md
19. Feb 28 1947 (Date rec'd by registrar) C. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28 1947, at 7 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 6 1944, to Feb 28 1947
and that I last saw h.. alive on Feb 27 1947

Immediate cause of death	DURATION
Pulmonal & cerebral Sclerosis	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Date signed 2-28-47

2-25

2-810 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

01529

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years 8 mons. 26 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 37 yrs. 8 mons. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George Calvert Haferkorn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1880

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER
12. Name: Gustave
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susana Angelmaier
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 25/47 (month) (day) (year)
Cemetery or crematory: Balto Cem.
Location: Balto Md
18. Funeral director: Uhlich Funeral Home
Address: 2008 Calvert St

19. Feb 22 1947 (Date rec'd by registrar) Harry Beer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22, 1947 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 to Feb. 22, 1947 and that I last saw him alive on February 22 1947

Immediate cause of death	DURATION
Arteriosclerosis	
prior to	1945
Due to	
Due to	
Other conditions: Schizophrenia, paranoid type	40 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robt Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 2/22/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-a)

CERTIFICATE OF DEATH

01530

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Honorable Daniel Hartzler

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	M.

6.(b) Name of husband or wife: Katherine Hartzler

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): February 18, 1912

8. AGE: Years: 34 | Months: 11 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Smithville Ohio

(Town, county, and state)

10. Usual occupation: Funeral Director

11. Industry or business

FATHER

12. Name: Daniel D. Hartzler

13. Birthplace: Indiana

MOTHER

14. Maiden name: Fannie E. Emmert

15. Birthplace: Ohio

16. Informant: Byron E. Hartzler

Address: New Windsor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 19 - 1947 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: H. H. Hartzler & Sons

Address: Union Bridge & New Windsor, Md

19. Feb. 17 1947 (Date rec'd by registrar) Eichelman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 1947, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: 2-16-47

2-25

2-10 —— 2-10

01531

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 month, 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 617 Camel Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES HAYNIE

3.(b) Social Security Number: 217-05-5475

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 17, 1890

8. AGE: Years	Months	Days	If less than one day
56	8	13	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Wine Factory Worker
11. Industry or business

FATHER
12. Name: Richard Haynie
13. Birthplace: Virginia

MOTHER
14. Maiden name: Nellie Russ
15. Birthplace: Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/13/47 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City
18. Funeral director: Geo. E. Kelson
Address: 1303 Presstman St.

19. 2-10 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10, 1947, at 12.00 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16, 1946, to Feb. 10, 1947 and that I last saw him alive on February 10, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Apr. 1st 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henrytnn, Md. Date signed: 2-10-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-740.1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

CERTIFICATE OF DEATH

01532

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address (Where death occurred): Springfield State Hospital

How long in hospital or institution? 3 months.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Sarah Alice Heilman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 1st - 1871

8. AGE: Years: 75 | Months: 1 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Alexandria Penna (Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business:

FATHER — 12. Name: Calvin Ulysses Heilman

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Dolly McElvaine

MOTHER — 15. Birthplace: Pa

16. Informant: Mrs Mary Keefer

Address: Mary Gatlin, Hagerstown Md

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: Feb 6 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Greencastle Penna.

18. Funeral director: Jacob A. Keefer

Address: Greencastle, Penna.

19. Feb 5 1947 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4th 1947, at 10-30 a M

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from Oct 5th 1946 to Feb 4th 1947

and that I last saw her alive on Feb 4th 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 wk
Due to:	
Due to: Cer. Arteri Sclerosis	?
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: W J Martin M.D.

M. D. or other

Address: Sykesville Md Date signed: 2/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (872)

CERTIFICATE OF DEATH

01533

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 5 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 years, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. 639 Bartlett Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: James B. Hobbs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Florence Messick

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): November 20, 1890

8. AGE: Years	Months	Days	If less than one day
56	2	20	....hrs. ....min.

9. Birthplace: Baltimore City, Maryland (Town, county, and state)

10. Usual occupation: paper cutter

11. Industry or business: printing & publishing

FATHER 12. Name: James B. Hobbs

FATHER 13. Birthplace: Unk-

MOTHER 14. Maiden name: Elizabeth Viertel

MOTHER 15. Birthplace: Unk-

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-12-47 (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Balto. Md.

18. Funeral director: Wm. Cook. Inc.

Address: 217 St Paul St.

19 Feb. 11 19 47 C. Harry Weis (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 19 47 at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to Feb. 10 19 47 and that I last saw him alive on February 10 19 47

Immediate cause of death	DURATION
Carbuncles (2)	5 days
Due to	
Due to	
Other conditions: Huntington's chorea	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D.

Springfield State Hospital M. D. or other

Address: Sykesville, Maryland Date signed 2-10-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★01534

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 14 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 609 N. Bethel Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: FILMORE HUGHES

3. (b) Social Security Number: 217-09-0975

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Betty Hughes

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Unknown, 1896

8. AGE: Years	Months	Days	If less than one day
51	?	?	....hrs. ....min.

9. Birthplace: Deals Island, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Levin Hughes

FATHER — 13. Birthplace: Deals Island, Md.

MOTHER — 14. Maiden name: Hester Hughes

MOTHER — 15. Birthplace: Deals Island, Md.

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14 1947 (month) (day) (year)

Cemetery or crematory: Deals Island Md.

Location: Eastern Shore Md

18. Funeral director: Mrs Robert Elliott & daughter

Address: 1129 N. Caroline St.

19. Feb. 12, 1947 (Date rec'd by registrar) Albert A. Leuchtman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12, 1947 at 10.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28, 1946 to Feb., 12, 1947 and that I last saw h...im alive on February 12, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Foman, M.D. (M. D. or other)

Address: Henryton, Md. Date signed: 2-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-740 ——— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

01535

CERTIFICATE OF DEATH

Reg. Dist. No. 790

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Middleburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Middleburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Elsie M. Hyde

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Charles P. Hyde

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 26, 1876

8. AGE: Years	Months	Days	If less than one day
70	7	23	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: John Coleman

13. Birthplace: Md

MOTHER

14. Maiden name: Lucretia Eyler

15. Birthplace: Md.

16. Informant: Mrs. Charles Sherman

Address: Middleburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 21, 1947 (month) (day) (year)

Cemetery or crematory: Middleburg

Location: Middleburg, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. Feb. 21 1947 (Date rec'd by registrar) Nancy M. Riley Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 1947 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Feb. 1947

and that I last saw h.. alive on Feb. 18 1947

Immediate cause of death	DURATION
(a) Cerebral Hemmhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Mason M.D. M. D. or other

Address: Union Bridge Date signed Feb 19

1-35

BIRTHDATE AND AGE changed by letter from Dr. Hoffman filmed G109 3-4-47 LL 01536

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 741

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1335 Pennsylvania Ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN HYMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Louise Hyman
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): December 23, 1879 (1890) ~~March 25, 1890~~

8. AGE: Years	Months	Days	If less than one day
56 ~~67~~	2 ~~10~~ 11	1 ~~13~~	hrs. min.

9. Birthplace: Colorado (Town, county, and state)
10. Usual occupation: Brick Layer
11. Industry or business:

FATHER
12. Name: Andrew Hyman
13. Birthplace: Colorado

MOTHER
14. Maiden name: Louisa Garey
15. Birthplace: Colorado

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-1-47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Section Hill
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave.

19. Feb. 26, 1947 (Date rec'd by registrar) Albert R. Swanbacker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1947, at 2.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Febuary 18, 1947 to Feb. 26, 1947 and that I last saw him alive on February 26, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 2-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-740 ——— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01537

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1303 Myrtle Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MILDRED JOYCE HYMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: Nathan Hyman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 28, 1924

8. AGE: Years	Months	Days	If less than one day
22	11	27	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Laundry Worker

11. Industry or business:

FATHER — 12. Name: Stewart Smith

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Hattie Bradley

MOTHER — 15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 3 47 (month) (day) (year)

Cemetery or crematory: Mount Auburn

Location: Balto. Md.

18. Funeral director: R. D. Williams

Address: 3224 E. Chase St.

19. Feb. 25, 1947 (Date rec'd by registrar) Albert R. Scrudham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25, 1947, at 4.20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19, 1947, to Feb. 25, 1947 and that I last saw her alive on February 25, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Kuhn, M. D. M. D. or other

Address: Henryton, Md. Date signed: 2/25/47

1-25

2-740 ——— 1-10

01538

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 month, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1032 S. Eutaw Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GLADYS MARIE JONES

3.(b) Social Security Number: 219-20-9848

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Robert Jones
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): June 4, 1918

8. AGE: Years	Months	Days	If less than one day
28	8	19	hrs. min.

9. Birthplace: Alton, Va. (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business:

FATHER
12. Name: Junious McCoy
13. Birthplace: Alton, Va.

MOTHER
14. Maiden name: Mary Bonnett
15. Birthplace: Alton, Va.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/28/47 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brooklyn, Md.
18. Funeral director: Elroy D. Wilson
Address: 1000 Brant-lyn ave

19. 2/23 19 47 (Date rec'd by registrar) Albert M. Trumbauer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 19 47, at 11.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25, 19 46, to Feb., 23, 19 47
and that I last saw her alive on February 23, 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben M. Lucas M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

01539

Reg. Diat. No. 760

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Westminster (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Abt 30 yrs

Hospital, Institution, or street address where death occurred: 96 Penna. Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No. 96 Penna. Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bessie Lowe Kauffman

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife John W. Kauffman 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1884

8. AGE:

Years	Months	Days	If less than one day
62	11	1	hrs. min.

9. Birthplace Bark Hill Carroll Co. Md. (Town, county, and state)

10. Usual occupation Home-wife

11. Industry or business

FATHER 12. Name Nathan Lowe

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Alice Eyler

15. Birthplace Carroll Co. Md.

16. Informant Mr. John W. Kauffman

Address 96 Penna Ave Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 1 (month) 47 (day) (year)

Cemetery or crematory Uriders Cemetery

Location near Westminster Md.

18. Funeral director J. E. Myers

Address Westminster Md.

19. 2/27 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1947, at 3a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to 2/27 1947

and that I last saw her alive on 2/26 1947

	DURATION
Immediate cause of death Cerebral Thrombosis	3 days
Due to Arteriosclerosis	3 yrs
Due to	
Other conditions Hypertension, Uraemia, Neuritis (Include pregnancy within 3 months of death)	3 yrs 6 mos.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Greenwood M. D. or other

Address Westminster Date signed 2/3/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-6)

CERTIFICATE OF DEATH

01540

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 15 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Elkridge Farm
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MILDRED KEETER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 26, 1927

8. AGE:	Years	Months	Days	If less than one day
	19	11	11	hrs. min.

9. Birthplace: Marion, N. C.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Anglus Keeter
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Bertha Carson
15. Birthplace: Union Mills, N. C.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-9-47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Cedar Hill Md.

18. Funeral director: Nicholas Halstead
Address: 918 Druid Hill Ave.

19. 2-7 19 47 (Date rec'd by registrar) Albert R. Swankhan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 19 47 at 1.25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 19 46, to Feb., 7, 19 47
and that I last saw her alive on February 7, 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1945

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Wyman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 2-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-d)

CERTIFICATE OF DEATH

01541

Reg. Dist. No. 760

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town).

How long in above place of death? Most of his entire life

Hospital, Institution, or street address where death occurred:
44 Longwell Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 44 Longwell Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Claude Truitt Kimmey

3.(b) Social Security Number: 212-01-8694

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Anna Virginia Kimmey

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Feb. 17 1889

8. AGE: Years: 57 | Months: 11 | Days: 26 | If less than one day: ... hrs. ... min.

9. Birthplace: Westminster, Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Manager of Printing office

11. Industry or business:

FATHER
12. Name: William J. Kimmey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachel Hook
15. Birthplace: Maryland

16. Informant: Mrs. C. Claude T. Kimmey

Address: 44 Longwell Ave. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/16/47 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. E. Myers, Jr.

Address: Westminster, Md.

19. 2/14 19... R. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 13th 19.47, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15th 19.46, to Feb. 13th 19.47

and that I last saw him alive on Feb. 13th 19.47

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 hours
Due to: Cardio-Vascular Hypertensive Disease	2 or 3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: V. T. Billingslea, M.D.
M. D. or other

Address: Westminster, Md. Date signed: 2-14-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-3

Evidence for tthe change of age is shown on G 109 3/10/47

P 01542

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

CERTIFICATE OF DEATH

Reg. Dist. No. 740

1. PLACE OF DEATH:

County: Carroll Co

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs 2 mo 7 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 35 yrs 2 mo 7 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Frank Gilbert Knorr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1896 Dec 2nd

8. AGE: Years	Months	Days	If less than one day
50	5 11		hrs. min.

9. Birthplace: md (Town, county and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER 12. Name: William Knorr

FATHER 13. Birthplace: md

MOTHER 14. Maiden name: Annie Rubenstein

MOTHER 15. Birthplace: md

16. Informant: Anthony Knorr

Address: 3916 Yolanda Rd Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct-19th 1947 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: E North Ave Ext

18. Funeral director: Leo G. Lebrook

Address: 1701-03 N. Pulaski Park Ave

19. 2-17-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 15th 1947, at 10-32 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8th 1946, to Oct 15 1947

and that I last saw h[illegible]ive on Oct 15 1947

Immediate cause of death	DURATION
Due to: Epilepsy	45 yrs
Due to: Status Epilepticus	2 da
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. H. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed 2/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

VS A15 9-45-15M

01543

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1700)

CERTIFICATE OF DEATH

Reg. Diat. No. 746

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Route Severnside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Route 26 - East Edgewood

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Edgewood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Liberty Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Paul Peter Kunkel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

8.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1936

8. AGE: Years	Months	Days	If less than one day
10	1	16	hrs. min.

9. Birthplace: Balto. County, Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: John Clarence Kunkel

FATHER — 13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Goldie L. R. Edman

MOTHER — 15. Birthplace: Baltimore Maryland

16. Informant: John A. Kunkel

Address: Liberty Rd. Edgewood, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10 - 1947 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road. Balto. Md

18. Funeral director: Frank H. Newell

Address: Pikesville. Maryland.

19. Feb. 7 1947 (Date rec'd by registrar) Henry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Fractured Skull	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 2-7-47

Where did injury occur? Mr Sy Route 26 Anne Arundel Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 26

Means of injury: Struck by Automobile Injured at work? No

23. SIGNATURE: James L. Mount Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: 2-7-47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 01544

Reg. Dist. No. 760

1. PLACE OF DEATH:
County Carroll
City or town Gist, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Gist
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. F. D. #2 Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William E. Law

3.(b) Social Security Number [redacted]

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18, 1927

8. AGE: Years	Months	Days	If less than one day
19			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation None.
11. Industry or business

FATHER
12. Name Edgar W. Law.
13. Birthplace Maryland.

MOTHER
14. Maiden name Minerva L. McGowan
15. Birthplace Maryland.

16. Informant Mrs. Minerva L. Hoke.
Address R. F. D #2, Gist, Carroll Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 12, 1947 (month) (day) (year)
Cemetery or ~~crematory~~ Sand Ridge
Location Pikesville, Md.

18. Funeral director Chenoweth & Donovan
Address 3 p 15-17 Chestnut Ave Baltimore Md.

19. 2/10 1947 (Date rec'd by registrar) H. Clifford Snead Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1947 at 3 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-9 1947 to Feb-10 1947 and that I last saw him alive on Feb-9- 1947

Immediate cause of death	DURATION
Myocarditis (chr.)	?
Progressive Myocarditis	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

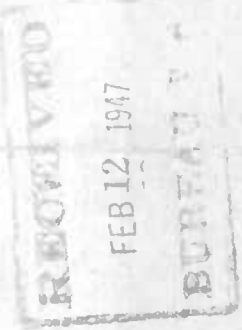
23. SIGNATURE W. C. Jennette, M.D. M. D. or other
Address Westminster Date signed 2-10-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Sa. C. W. Jennette
103 Main St
Centerville 390



1-35

AGE: Bapt. cer. (from brother, informant, thru funeral director) showing birthdate July 21, 1899, bapt. at St. Johns church, Parkville Sep 3, 1899. Film G108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01545

Reg. Dist. No. 74

2-13-47 L

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs 4 mos 10 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 yrs 4 mos 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore Co.

City or town: Towson (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Henry Leist

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 21st - 1899

8. AGE: Years	Months	Days	If less than one day
47	6	15	1899 ...hrs. ...min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Dependent.

11. Industry or business:

FATHER 12. Name: Henry Leist

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Anna Schmidt

MOTHER 15. Birthplace: Germany

16. Informant: Henry Leist

Address: Towson Md R.D. #6

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/9/47 (month) (day) (year)

Cemetery or crematory: St. Johns Luth.

Location: Balto. Co. Md.

18. Funeral director: Loudon Funeral Serv.

Address: 7401 Belair Rd.

19. Feb. 7 1947 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6th 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from Sept. 26 1946 to Feb 6th 1947 and that I last saw h... alive on Feb 6th 1947

	DURATION
Immediate cause of death: Bronchopneumonia	3 da
Due to: Status Epilepticus	unk
Other conditions: Epilepsy	40 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Masters M.D. M. D. or other

Address: Sykesville Md. Date signed 2/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 01546 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, Institution, or street address where death occurred: Lane View Nursing Home

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Maryland County: Carroll

City or town: Manchester Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Laura V. Lippy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Christian V. Lippy

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Oct. 24, 1872

8. AGE: Years 74 | Months 3 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Maryland Carroll Co. (Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business

FATHER 12. Name: William Kelear

13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary Shriver

15. Birthplace: Maryland

16. Informant: Christian V. Lippy

Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-12-47 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Manchester Md

18. Funeral director: Carol Ritter's Sons

Address: Manchester Md.

19. Feb 10 1947 Mrs. N. P. J. Denner (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1947, at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to February 10 1947 and that I last saw h[illegible] alive on February 8 1947

Immediate cause of death: Primary Carcinoma Liver — DURATION 7

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Buckland M. D. or other

Address: Westminster Md Date signed 2-10-47

1-35

Evidence for the addition of color and sex is shown on G 108 2/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

01547 Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster R.D. #4
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 85 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster R 4
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henritta A. Long

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6.(b) Name of husband or wife Jacob J. Long
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1861

8. AGE: Years 85 Months 8 Days 15 If less than one day hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Daniel Mitten
13. Birthplace Md.

MOTHER
14. Maiden name Sarah E. Crouse
15. Birthplace Md.

16. Informant Charles W. Long
Address Westminster, Md. R.D. #4

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 4-1947 (month) (day) (year)
Cemetery or crematory Leister Cemetery
Location Westminster, Md. # 4

18. Funeral director H. Bankard & Son
Address Westminster, Md.

19. 2/3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 1 1947, at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Feby 1 1947, and that I last saw her alive on Jan. 28 1947.

Immediate cause of death	DURATION
a. Acute Cardiac Dilatation	6 hrs
Due to: Chronic Myocarditis	2 yrs
Due to: Chronic Interstitial Nephritis	4 yrs
Other conditions: arteria sclerosis	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

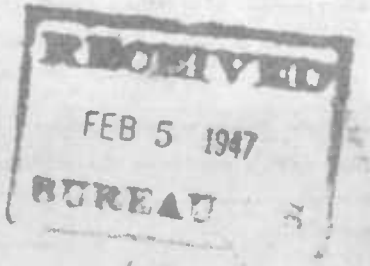
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R Fout M.D. (M.D. or other)
Address Westminster Md. Date signed 2-2-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



1-35

01548

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-d)

CERTIFICATE OF DEATH

BC Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years, 3 months, 19 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 years, 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 504 South Macon Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lula Norris Lucas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ~~unknown~~ Dec. 28, 1884

8. AGE:

Years	Months	Days	If less than one day
~~XX~~ 62	1 unknown	24	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER
12. Name: Al Norris
13. Birthplace: unknown

MOTHER
14. Maiden name: Louisa Hemiller
15. Birthplace: Baltimore, Md.

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 24-47 (Month) (day) (year)
Cemetery or crematory: Baltimore Cemetery
Location: East End North Ave

18. Funeral director: William Cook Jgr.
Address: 1217 St Paul Street Balto Md

19. Feb. 22 19 47 C. Haney Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21, 1947, at 6.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942, to February 21 1947 and that I last saw her alive on February 21 1947

Immediate cause of death	DURATION
Carcinoma of the rectum	2 years
Due to	
Due to	
Other conditions: Tabo-paresis	10 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: June Hitchmen, M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 2-21-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

FILM No. G 1 - JUN 13 1947 Evidence for the addition of residence is shown on

FILM No. G 1 - JUN 23 1947

STATE OF MARYLAND—CERTIFICATE OF DEATH

01549

1. PLACE OF DEATH

County Carroll Registration Dist. No. 750

Village or City near Manchester No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Jacob B Lynard

(a) Residence: No Nr Manchester, Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elezebith Lynard Deceased

6. DATE OF BIRTH (month, day, and year) April 22. 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	9	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Manchester. Md. Carroll

FATHER

13. NAME John J Lynard

14. BIRTHPLACE (city or town) (State or country) Penna.

MOTHER

15. MAIDEN NAME Elezebeth Frankfaster

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT (Address) Miss Nellie Lynard Westminster #3 Md.

18. BURIAL, CREMATION, OR REMOVAL Place Manchester Date 2-24, 1947

19. UNDERTAKER (Address) Jacob Waltz & Sons Manchester, Md.

20. FILED Feb. 27, 1947 Mrs. M. J. S. Demmer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February (Month) 21 (Day) 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1947, to Feb. 21, 1947

I last saw him alive on Feb. 20, 1947; death is said to have occurred on the date stated above, at 12:30 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	2-21-47
Other Contributory Causes of importance: Coronary Arterio Sclerosis	years

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Maurice C. Porterfield M. D.

(Address) Hampstead, Md.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01550

Reg. Diat. No. 760

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 282 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: William A. Manning

3.(b) Social Security Number: 213-09-8151

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Matilda F. Manning

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): October 17, 1887

8. AGE: Years	Months	Days	If less than one day
59	4	11	....hrs. ....min.

9. Birthplace: Westminster, Md.

(Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business:

FATHER

12. Name: Lewis P. Manning

13. Birthplace: Maryland

MOTHER

14. Maiden name: Emily J. Barnes

15. Birthplace: Maryland

16. Informant: Mrs. Ray Stiver

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3/3/47 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 3/1 (Date rec'd by registrar) 19 47 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28, 19 47, at 1p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h.... alive on ....19....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James F. Marsh, Deputy Medical Examiner M. D. or other

Address: Westminster, Md. Date signed 3/1/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01551

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 month, 13 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Turners Station (If outside city or town limits, write RURAL and give nearest town)

Street No. 112 Sollars Point Road (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: VIOLA MAYS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femlae	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4, 1928

8. AGE:

Years	Months	Days	If less than one day
18	9	5	hrs. min.

9. Birthplace: North Hampton County, N.C. (Town, county, and state)

10. Usual occupation: Bus Girl

11. Industry or business:

FATHER

12. Name: Hubert Mays

13. Birthplace: Emporia, Va.

MOTHER

14. Maiden name: Geneva Prince

15. Birthplace: North Hampton Co., N. C.

16. Informant: Deceased

Address:

17. Ship (Burial, cremation, or removal. Which?) Date thereof 2-12-47 (month) (day) (year)

Cemetery or crematory: Johnsons Cem

Location: Gaithersburg Md.

18. Funeral director: Payne Sanders

Address: 1412 E. Preston St.

19. Feb., 9, 1947 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9, 1947, at 4.40P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26, 1946, to Feb., 9, 1947 and that I last saw her alive on February 9, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Mar. 2nd 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Burhen Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 2-9-47

1-35

2-740. — 1—10

MARYLAND STATE DEPARTMENT OF HEALTH

01552

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 1

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 month, 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1214 Argyle Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MAMIE LOU MCKENSTRY

3.(b) Social Security Number: 248-26-5699

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Isiah McKenstry
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): April 25, 1915

8. AGE: Years	Months	Days	If less than one day
31	10	12	hrs. min.

9. Birthplace: Greenville, S. C.
(Town, county, and state)
10. Usual occupation: Maid
11. Industry or business

FATHER
12. Name: Robert Barksdale
13. Birthplace: Lawrence, S. C.

MOTHER
14. Maiden name: Ella Ward
15. Birthplace: South Carolina

16. Informant: Deceased
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof 3 3 47 (month) (day) (year)
Cemetery or crematory: Greenville S C
Location: Greenville S. C.
18. Funeral director: R. L. Williams
Address: 322 N. Church St.

19. Feb. 27, 1947 (Date rec'd by registrar) Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27, 1947, at 6.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1947, to Feb., 27, 1947, and that I last saw her alive on February 27, 1947.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Offman M.D. M. D. or other
Address: Henryton, Md. Date signed: 2-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2 - 740 — 1 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Diat. No. 0176

1. PLACE OF DEATH:
County Carroll Co.
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. One mile from Westminster on Hanover Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Mrs. Mary Jane Mumford

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Walter S. Mumford
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 27 ? 1876

8. AGE: Years	Months	Days	If less than one day
About 70			hrs. min.

9. Birthplace Burlington, Vt.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Joseph Flynn
13. Birthplace Schenectady, N.Y.

MOTHER
14. Maiden name Catherine Mulligan
15. Birthplace Burlington, Vt.

16. Informant Mrs. C. E. Mumford
Address Westminster, Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10, 47 (month) (day) (year)
Cemetery or crematory: St. Johns Cem.
Location Westminster Md.
18. Funeral director J. S. Myers Jr.
Address Westminster. Md.
19. 2 F 47 (Date rec'd by registrar) 19 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1947, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 1946, to Feb 6 1947
and that I last saw her alive on Feb 3 1947

Immediate cause of death	DURATION
Carcinoma of Breast with Local Failure	7 mos.
Due to Metastases	2+ yrs
Due to Hypertension	3+ yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Rose Virkens M. D. or other
Address Westminster Date signed 2-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01554

Reg. Dist. No. [redacted] 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Mount Airy (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mount Airy (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: HARRY SMITH NIKIRK, SR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Laura Edna Spurrier

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): March 16, 1882

8. AGE: Years	Months	Days	If less than one day
64	10	23	...hrs. ...min.

9. Birthplace: Frederick County Maryland (Town, county, and state)

10. Usual occupation: Retired Engineer

11. Industry or business: B & O Railroad Company

FATHER 12. Name: George D. Nikirk

FATHER 13. Birthplace: Frederick County Maryland

MOTHER 14. Maiden name: Amanda Smith

MOTHER 15. Birthplace: Frederick County Maryland

16. Informant: Mrs. Laura Nikirk

Address: Mount Airy, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/12/47 (month) (day) (year)

Cemetery or crematory: Marvin Chapel Cemetery

Location: Plane #4, Maryland

18. Funeral director: M. R. Etchison and Son

Address: Frederick, Maryland

19. Feb. 12 1947 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9, 1947, at 1:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23 1946, to February 9, 1947

and that I last saw h[illegible] alive on January 31 1947

Immediate cause of death: arteriosclerotic cardio vascular disease. — DURATION: 5 years.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

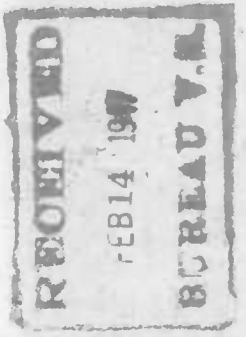
Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other

Address: Damascus, Md. Date signed: 2/10/47

Mr. Kerr
Dawsonville

M. R. Etchison and Son,
106 E Church St.
Frederick, Md



1-35

01555

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 740

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 11 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore - 14
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5904 Harford Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emery Pandak

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Borosh Pandak

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 8/25/91

8. AGE: Years	Months	Days	If less than one day
54	6	1	hrs. min.

9. Birthplace Barca, Hungary
(Town, county, and state)

10. Usual occupation Chiropractor

11. Industry or business

FATHER 12. Name Emery Pandak

FATHER 13. Birthplace Barca, Hungary

MOTHER 14. Maiden name Bertha Botka

MOTHER 15. Birthplace Barca, Hungary

16. Informant Records, Springfield State Hospital

Address Sykesville, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Mar. 4 1947 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Washington

18. Funeral director C.H. Weer

Address Sykesville, Md.

19. Mar 1 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 19 47, at 8:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/15/47 19 , to 2/26/ 19 47 and that I last saw h im alive on 2/26 19 47

Immediate cause of death	DURATION
Portal Cirrhosis	6 weeks
Due to	
Due to	
Other conditions Carcinoma of Sigmoid	unknown
Psychosis c Chronic Alcoholism	2 months

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results Above - also, fistula from sigmoid to bladder.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichert, M.D.
M. D. or other

Address Sykesville, Maryland Date signed 2/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

BC 01556

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 1 month, 24 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2810 Chelsea Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY PARKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown, 1893

8. AGE: Years	Months	Days	If less than one day
54	?	?	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Jason Parker
13. Birthplace: Unknown

MOTHER
14. Maiden name: Annie Barnes
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-13-47 (month) (day) (year)

Cemetery or crematory: Sacred Heart Cem.

Location: Balto. Md.

18. Funeral director: C. Harry Weer

Address: Lyndhurst, Md.

19. Feb. 12, 1947 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12, 1947 at 2.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18, 1942 to Feb., 12, 1947 and that I last saw her alive on February 12, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert W. Foss, M. D.
M. D. or other

Address: Henryton, Md. Date signed: 2-12-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25

2-740 —— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-7

CERTIFICATE OF DEATH

BC 01557 Reg. Dist. No. 24-0

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1928 W. Lexington
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Daniel Langhorne Powell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Edith Hazelton Powell
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 11, 1884

8. AGE: Years	Months	Days	If less than one day
62	8		..... hrs. ..... min.

9. Birthplace: Lynchburg, Va. (Town, county, and state)
10. Usual occupation: Guard
11. Industry or business: Boat yard
FATHER 12. Name: Arthur Temple Powell
FATHER 13. Birthplace: Richmond, Va.
MOTHER 14. Maiden name: Nellie Langhorne
MOTHER 15. Birthplace: Virginia
16. Informant: Hospital records
Address
17. Burial (Burial, cremation, or removal, Which?) Date thereof 2-14-47 (month) (day) (year)
Cemetery or crematory: Spring Hill Cemetery
Location: Lynchburg, Va.
18. Funeral director: Quigley Funeral Home
Address: Lynchburg, Va.
19. Feb. 12 1947 (Date rec'd by registrar) C. Harry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11, 1947 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6, 1947, to Feb. 11, 1947 and that I last saw him alive on Feb. 11, 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	15 days (known)
Syphilis	3 yrs.
Psychosis with Chronic Alcoholism	4 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M.D. or other
Address: Springfield State Hospital Date signed 2/11/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

re 01558

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 9 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution? ,

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 631 Smithson Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ALPHA CHRISTINE QUILLE

3.(b) Social Security Number: 215-24-6395

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: James Quille
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): January 4, 1918

8. AGE:

Years	Months	Days	If less than one day
29	1	3	hrs. min.

9. Birthplace: Caroline County, Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER
12. Name: Owen Spruel
13. Birthplace: Edgecomb County, N. C.
14. Maiden name: Josephine Anderson
15. Birthplace: Caroline County, Va.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 11, 1947 (month) (day) (year)
Cemetery or crematory: Arbutus Mem. Park
Location: Balt. Co. Md.

18. Funeral director: Mrs. George W. Holler
Address: 1631 Druid Hill Ave.

19. 2-7 (Date rec'd by registrar) 19 47 Albert A. Swarbrick Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7, 19 47, at 11.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 19 46, to Feb., 7, 19 47
and that I last saw her alive on February 7, 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fuman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 01559

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1008 W. Lanvale Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GEORGE DEWEY ROBINSON

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19, 1899

8. AGE: Years	Months	Days	If less than one day
47	9	29	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Boot Black
11. Industry or business

FATHER
12. Name: Alfred Robinson
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Maggie (Unknown)
15. Birthplace: North Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-21-47 (month) (day) (year)
Cemetery or crematory: Arbutus Mem. Pk.
Location: Baltimore Co., Md.
18. Funeral director: Mrs. Hes. H. Holland
Address: 1631 Druid Hill ave.
19. Feb. 18, 1947 (Date rec'd by registrar) Albert R. Swandale Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18, 1947 at 1.55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jaunary 28, 1947, to Feb. 18, 1947 and that I last saw him alive on February 18, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fraser, M. D. (M. D. or other)
Address: Henryton, Md. Date signed: 2-18-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-J

CERTIFICATE OF DEATH

01569

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 171 E. Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Regina C. Rose

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: John J. Rose
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 22, 1873

8. AGE: Years	Months	Days	If less than one day
73	11	30	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Henry B. Pentz
13. Birthplace: Maryland

MOTHER
14. Maiden name: Georgianna Perry
15. Birthplace: Maryland

16. Informant: Miss Irene Rose
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/24/47 (month) (day) (year)
Cemetery or crematory: St. John's Catholic Cem.
Location: Westminster, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 2/22/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21 1947, at 8 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1946, to Feb. 21 1947 and that I last saw her alive on Feb. 21 1947.

	DURATION
Immediate cause of death: Edema of Lungs	14 hours
Due to: Cardio-vascular hypertensive disease	2 years?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. L. Billingslea M. D. or other
Address: Westminster, Md. Date signed 2-22-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01561

Reg. Dist. No. 741

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: OLLIE SCARBOROUGH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Charles F. Scarborough
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 17, 1902

8. AGE: Years	Months	Days	If less than one day
44	2	6	..... hrs. ..... min.

9. Birthplace: Norfolk, Va.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Clearence Owens
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Shaw
15. Birthplace: Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-26-47 (month) (day) (year)
Cemetery or crematory: Snow Hill
Location: Snow Hill Md
18. Funeral director: Clay E. Timmons
Address: Snow Hill Md

19. 2-23 (Date rec'd by registrar) 19 47 Albert R. Scarborough Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 1947, at 5.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3, 1947, to Feb., 23, 1947 and that I last saw her alive on February 23, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Miles M. Foreman, M. D. (M. D. or other)
Address: Henryton, Md. Date signed: 2-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

Z-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162a)

CERTIFICATE OF DEATH

01562 4 P

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr., 7 mo., 11 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 yr., 7 mo., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Robert Edward Schaefer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 5, 1866

8. AGE: Years	Months	Days	If less than one day
80	9	17	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: clerk

11. Industry or business

FATHER
12. Name: John Otto Schaefer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Caroline Warwick
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jul 25-1947 (month) (day) (year)
Cemetery or crematory: Lorraine Cemetery
Location: Balto. Md.

18. Funeral director: Geo L Boyer Jr
Address: 512 Hollins St

19. 2-24 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 1947 at 2:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26 1944 to Feb. 22 1947
and that I last saw him alive on February 22 1947

Immediate cause of death	DURATION
Senile psychosis, simple deterioration (senility)	12 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D. M. D. or other
Address: Springfield State Hospital Sykesville, Maryland Date signed 2-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61899

Reg. Diat. No. 74

1. PLACE OF DEATH: -
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: THOMAS EDWARD SELLMAN

3. (b) Social Security Number: 220-09-4262

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Divorced

6.(b) Name of husband or wife: Minnie Sellman
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): February 6, 1903

8. AGE: Years	Months	Days	If less than one day
44	0	18	hrs. min.

9. Birthplace: Upper Marlboro, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Wilson Sellman
13. Birthplace: Maryland
MOTHER 14. Maiden name: Susie Owens
15. Birthplace: Maryland
16. Informant: Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28/47 (month) (day) (year)
Cemetery or crematory Plummer
Location Drury, Md.
18. Funeral director J. B. Dilmore
Address Annapolis
19. Feb. 24, 1947 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1947, at 9.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13, 1947, to Feb., 24, 1947 and that I last saw him alive on February 24, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Nathan W. Bowen, M. D. M. D. or other
Address Henryton, Md. Date signed 2/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-740 — 1-60

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01563

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium(Colored)
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 124 Aisquith Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: LUCILLE WHITE SIMPSON

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: James Simpson
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): June 24, 1914

8. AGE:

Years	Months	Days	If less than one day
32	7	15	hrs. min.

9. Birthplace: Darlington, S.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas White
13. Birthplace: Florence, S.C.

MOTHER
14. Maiden name: Lillian Witherspoon
15. Birthplace: Florence, S.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 12 1947 (month) (day) (year)
Cemetery or crematory: Mt Calvery Cem.
Location: Brooklyn, Md
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley ave

19. Feb. 9 19 47 (Date rec'd by registrar) Albert L. Swanhart deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 19 47 at 4:40 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 9 19 47 to Feb. 9 19 47 and that I last saw her alive on Feb. 9 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis	June 1 1939
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: Feb. 9, 194

7

1-25

2-740

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

01564

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Charles St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Clinton Sloop.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Ella M. Beaver

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Dec. 27 - 1886

8. AGE: Years	Months	Days	If less than one day
60	1	7	....hrs. ....min.

9. Birthplace Westminster, Md. (Town, county, and state)

10. Usual occupation House Painter

11. Industry or business

FATHER 12. Name Jefferson Sloop

FATHER 13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Annie Reigle

MOTHER 15. Birthplace Carroll Co. Md.

16. Informant Ella Sloop

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7 - 1947 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard Sons

Address Westminster, Md.

19. 2/5-47 19.... (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION about.

20. DATE OF DEATH Feb. 4 19 47 at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Coronary disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

....Date of op....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE James I. Shook Deputy Medical Examiner M.D. or other

Address Westminster Md. Date signed 2-4-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

01565

CERTIFICATE OF DEATH

Reg. Dist. No. 74 0

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 years 17 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 36 years 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harvey Stiffler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Separated

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 10th, 1878

8. AGE: Years	Months	Days	If less than one day
68 ~~xx~~	11	17	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Emanuel Stiffler
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Thomas
15. Birthplace: Pennsylvania

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 28, 1947 (month) (day) (year)
Cemetery or crematory: Steltz's Cemetery
Location: York Co., Pa.

18. Funeral director: Edward C. Tipton
Address: Hampstead, Md.

19. Feb 26 1947 (Date rec'd by registrar) C. Harvey Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1947, at 12:55a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1946, to Feb. 26, 1947 and that I last saw him alive on February 25, 1947

	DURATION
Immediate cause of death: Bronchopneumonia	4 days
Due to: Cerebral hemorrhage	8 days
Due to:	
Other conditions: Dementia Praecox	36 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Howard N. Fredrickson M.D. M. D. or other
Address: Springfield State Hospital Sykesville, Maryland Date signed: 2/26/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 01566 70 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Elias Stouffer

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife Harriet Ohler Stouffer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 30, 1849

8. AGE: Years	Months	Days	If less than one day
97	3	23	....hrs. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business

FATHER 12. Name John Stouffer

13. Birthplace Maryland

MOTHER 14. Maiden name Christiana Wolfe

15. Birthplace Maryland

16. Informant Mr. Ernest Bankard

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 26, 1947 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Taneytown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. Feb 25 1947 (Date rec'd by registrar) Ethel M Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1947, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F Monroe County Medical Examiner M. D. or other

Address Westminster Md. Date signed Feb 23-47

1-35

01567

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Diat. No. 740

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 8 mons. 11 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yrs. 8 mons. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Masonic Home
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank H. Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 14, 1855

8. AGE: Years	Months	Days	If less than one day
91	2	29	hrs. min.

9. Birthplace: Fair Hills, Cecil County, Md.
(Town, county, and state)
10. Usual occupation: School Teacher
11. Industry or business

FATHER
12. Name: John T. Thompson
13. Birthplace: Unk.

MOTHER
14. Maiden name: Jane Anderson
15. Birthplace: Unk.

18. Informant: Springfield State Hospital records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-18-47 (month) (day) (year)
Cemetery or crematory: Liberty Cemetery
Location: Fair Hill, Md.
18. Funeral director: William Cook, Jnr.
Address: 1217 St. Paul St. Baltimore

19. Feb. 14 1947 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13, 1947 at 3:00p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28, 1944 to Feb. 13, 1947 and that I last saw him alive on February 13, 1947

Immediate cause of death	DURATION
Arteriosclerosis	prior to 1943
Due to:	
Due to:	
Other conditions: Senile psychosis, paranoid type.	Prior to 1943

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May M.D.
M. D. or other
Address: Springfield State Hospital Sykesville, Maryland Date signed: 2/13/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-30

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01568

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 211 N. Carey Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CLIFTON THEODORE WILLIAMS

3.(b) Social Security Number: 219-12-7850

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Clementine Williams 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 18, 1900

8. AGE: Years	Months	Days	If less than one day
46	7	5	hrs. min.

9. Birthplace: Alpha, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: Wallace Williams

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Laura Davis

MOTHER 15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 27 1947 (month) (day) (year)

Cemetery or crematory: Mount Lebanon

Location: Howard County, Md.

18. Funeral director: H. A. Williams

Address: 322 N. Schroeder St

19. 2/23 (Date rec'd by registrar) 19 47 Albert R. Saunders Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 1947 at 3.00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 1947 to Feb., 23, 1947 and that I last saw him alive on February 23, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 7th 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Rowland W. Johnson M. D. (M. D. or other)

Address: Henryton, Md. Date signed: 2-23-47

1-25

2 — 740 —— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

01569

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

BC 7 Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 month, 20 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Mt. Winans, (Baltimore, Md)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2616 Hollins Ferry Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: EMMA WILLINGHAM

3.(b) Social Security Number: 215-16-9195

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Luke Willingham
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): October 31, 1918

8. AGE:	Years	Months	Days	If less than one day
	28	3	4	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Stock Maid
11. Industry or business:

FATHER
12. Name: William Lee
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Clara McPherson
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-8-47 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto Md.
18. Funeral director: Wm. A. Jackson
Address: 916 penna ave.

19. 2-5 (Date rec'd by registrar) 19 47 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5, 19 47 at 4.25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15, 19 46, to Feb. 5, 19 47 and that I last saw her alive on February 5, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Robert W. Rowan, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01570

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Edward C. Yingling

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Fannie Zile Yingling
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 9. 1866

8. AGE:

Years	Months	Days	If less than one day
80	11	2	hrs. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: retired farmer

11. Industry or business

FATHER
12. Name: Frederick Yingling
13. Birthplace: Md

MOTHER
14. Maiden name: Sarah Hesson
15. Birthplace: Md

16. Informant: Mrs. Edward M. Black
Address: Westminster, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 14, 1947. (month) (day) (year)
Cemetery or crematory: St. Matthew's
Location: Pleasant Valley, Md.

18. Funeral director: C.O. FUSS & SON
Address: Taneytown, Md.

19. Feb 11 1947 (Date rec'd by registrar) Clay Engle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11 1947, at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26 1947, to February 11 1947, and that I last saw him alive on February 10 1947.

Immediate cause of death: Coronary Occlusion (ORATION)
Enteric Sclerosis Leucocytosis
Hypertension & myocardial
Due to: Degeneration
Pneumonia Hypostatic 2/8/47
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other
Address: Westminster Md Date signed: 2/11/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25

2-760-1-10